Prequalification for the Medi-Cal EHR Incentive Program

DHCS and its stakeholders believe that it is both feasible and desirable to use existing state data sources to identify a large number of providers and clinics as eligible for the Medi-Cal EHR Incentive Program before they would apply through the State Level Registry. This will greatly decrease the amount of prepayment verification work for DHCS and will enable DHCS to do targeted outreach to prequalified providers and clinics. Separate methodologies for "prequalification" of providers and clinics are described below.

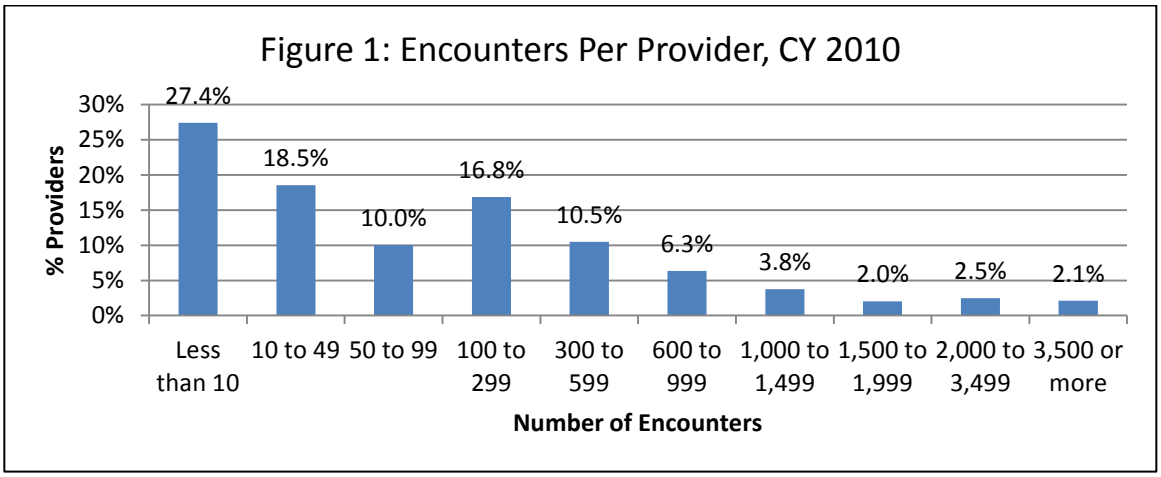
Provider Encounter Methodology

Encounter volume. The basic approach to "prequalification" of providers is to use their Medicaid encounter volume for the entire year of 2010. Providers who attain or surpass the number of Medi-Cal encounters that would be expected of a full-time primary care physician with 30% Medi-Cal volume during 2010 will be considered prequalified for incentive payments (if they are not hospital-based). These determinations will be made for individual providers by DHS staff before launch of the SLR by analyzing claims and encounter data in the state's MIS/DSS data warehouse.

Why primary care physicians? The threshold is based on primary care physicians because they see more patients than non-primary care physicians. In general, specialist physician visits are longer in duration due to the higher complexity of issues addressed. Visits by other EP types also tend to be longer, but for different reasons. The visits of physician assistants and nurse practitioners tend to be longer, perhaps because they require physician supervision or because they work based on a salary (Hooker, RS. Physician assistants in occupational medicine: how do they compare to occupational physicians. *Occupational Medicine* 2004, May;54(3): 153-8). Taylor LG. Comparing NPs, PAs, and Physicians. *Advance for NPs & PAs* 2007, Vol. 15(1), 53-54, 57-58, 60. (http://nurse-practitioners-and-physician-assistants.advanceweb.com/Editorial/Search/SearchResult.aspx?KW=comparing%20nps) Visits to dentists are longer in duration because of the complex procedures that dentists perform.

Minimum number of Medi-Cal encounter expected of a full time provider. The most recent American Academy of Family Physicians Practice Profile Study (June 2008) (http://www.aafp.org/online/en/home/aboutus/specialty/facts/5.html)(Appendix 1) found that in the Pacific region family physicians have 74.9 office visits, 3.9 hospital visits, 1.9 nursing home visits, and 0.4 home visits per week--for a total of 81.1 visits per week. Extrapolating from this, the total number of expected outpatient encounters in a 46 week work year for a full time physician would be 3721. To attain a 30% Medicaid volume a provider would need to have delivered 1116 encounters in 2010. A threshold set at this level is quite high by virtue of requiring a demonstration of service to Medicaid patients that is sustained over the entire year, not just during a 90 day period . Setting the threshold high for prequalification does not disadvantage provider types that may find it harder to prequalify than primary care physicians. Such providers can apply for the program through the usual channels using the two formulas specified in the Final Rule. These providers will indirectly benefit from prequalification because DHCS staff, not having to carry out prepayment verification on prequalified providers, will have more time and resources available to assess their applications.

Impact of Prequalification. Analysis of 2010 Medi-Cal data indicate that approximately 10.4% of Medi-Cal providers would be prequalified using a threshold of 1000 encounters. See Figure 1. Slightly less would be prequalified using a threshold of 1116 encounters.



This is roughly half of the 20% of Medi-Cal providers projected by the Lewin Group and McKinsey & Company analysis to be eligible for the incentive program. The break out by provider types is as follows: physicians—10%, dentists –12%, nurse practitioners –10%, and nurse midwifes –13%. There will be many part-time practice providers who are not 'prequalified" using this methodology, but who still will be able to establish eligibility under Formulas 1 or 2 by submitting their practice volumes. Similarly, there will be some pediatricians who will be eligible at the 20-29% practice level who are not prequalified using this methodology but will be able to establish eligibility at this level based on their submitted practice volumes. DHCS cannot prequalify pediatricians at the 20-29% level because of the inability to identify pediatricians reliably in its claims and encounter databases.

Safeguards. While it is possible that there may be some providers who are wrongly prequalified using this methodology because of practicing more than full time and treating few Medi-Cal patients during this additional practice time, this methodology will assure that they have attained the minimum number of encounters expected of a full time provider with 30% of patients covered by Medi-Cal for the entire year. This methodology will not result in fewer providers being eligible since providers who are not prequalified will still be able to apply using Formulas 1 and 2. This methodology actually may be more accurate than Formulas 1 and 2 in that it does not rely on "all payer" denominators reported by providers that cannot be verified against Medi-Cal claims or encounter data.

To deal with the probability that some providers may improperly bill for services rendered by other professionals despite this being illegal in California, prequalification will not be permitted for providers with more Medi-Cal encounters in 2010 than would be expected for full time practitioners. Based on the American Academy of Family Physicians survey this number would be 3721. Because some providers may work more than full time treating Medi-Cal patients, DHCS plans to set the upper limit of Medi-Cal encounters for prequalification purposes slightly higher at 4000. This will reduce the percentage of Medi-Cal providers offered prequalification by less than 2% (see Figure 1). As an additional safeguard, a special attestation form will be required for all providers utilizing the prequalification option that includes the following language:

> "I have been prequalified by Medi-Cal for the EHR Incentive Program based on having at least 1116 encounters with Medi-Cal patients in 2010 documented in claims and encounter data held by Medi-Cal. I attest that I personally delivered the services for at least 1116 Medi-Cal encounters in 2010."

Potential Advantages. As mentioned above, this prequalification methodology has the potential advantage of being an effective outreach tool for providers. Providers identified through prequalification will be sent letters or e-mails notifying them of their status, educating them about the program and encouraging them to apply for incentive payments. Providers, particularly in small office with manual billing systems, are more likely to apply for the program if they do not have to go to the work of generating the encounter data needed for Formulas 1 and 2. Such providers are probably the ones most in need of the help that the Medi-Cal EHR Incentive Program has to offer. This prequalification methodology will also assist DHCS by substantially decreasing the number prepayment verifications of patient volume data that DHCS will have be perform for providers applying to the SLR.

Panel Methodology

Panel Volume: The methodology for prequalification of managed care providers is largely derived from the encounter volume methodology. Data from various sources indicate that panel patients have 3.2 to 3.5 encounters per year on the average. The reference for 3.2 encounters per year is: Davies, MM, Davies M, Boushon B. Panel size: how many patients can one doctor manage? *Family Practice Management.* April 2007, 14(4):44-51 and http://www.aafp.org/fpm/20070400/44pane.html . DHCS has decided to adopt the more conservative 3.2 number for the purposes of prequalification, which will result in a higher threshold than using a higher number of encounters per year. Discussions with the Managed Care Eligibility Workgroup convened by DHCS revealed that that 3.2 encounters per year is supported by the data and experience of the participating Medi-Cal health plans.

Using 3.2 encounters per year and 3721 encounters per year, a provider who treats only managed care patients would be expected to treat approximately 1060 different managed care patients in a year. To achieve a 30% Medi-Cal threshold the provider would be expected to treat 318 Medi-Cal patients in a year. This number represents a high threshold since non-active patients (those not seen in the previous 12 months) are not factored out of the calculation methodology. DHCS would rather set the threshold too high than too low so as to not improperly prequalify some providers. See Appendix 2 for a detailed description of the methodology for identifying panel members prepared by DHCS's MIS/DSS contractor, Ingenix Government Solutions. This document was prepared based on identifying providers with at least 300 Medi-Cal panel patients per year, but the same methodology would apply to the higher threshold of 318. As with the other methodologies, hospital-based providers will not be prequalified.

DHCS does not directly track which PCPs are selected by Medicaid enrollees. However, this prequalification methodology essentially accomplishes this by using managed care encounter data to link patients to providers. Only PCPs would be expected to have a sufficient number of unique managed care patients linked to them to qualify for prequalification. DHCS is setting a higher bar for prequalification by managed care providers by allowing prequalification either based on panel members or encounters (see Patient Encounter Methodology above), but not based on panel members plus encounters.

Potential Impact: Analysis of encounter data for 2010 in the MIS/DSS data warehouse indicates that approximately 6% of Medi-Cal providers can be identified as having treated at least 300 Med-Cal managed care patients in 2010. Slightly less would be identified using the threshold of 318 panel patients.

Table 1. Medi-Cal Panel Patients

	Physician		Dentist	
	No.	%	No.	%
Number of Patients Per Provider				
Less than 10	17,577	56%	238	71%
10 to 49	7,271	23%	52	16%
50 to 99	2,343	7%	13	4%
100 to 299	2,479	8%	18	5%
300 to 599	921	3%	4	1%
600 to 999	403	1%	2	1%
1,000 to 1,999	355	1%	2	1%
2,000 or More	199	1%	4	1%
Total Providers	31,548	100%	333	100%
Providers with 300 or more patients	1,878	6%	12	4%
Patients Per Provider				
Mean	88		65	
Median	7		2	
Min	1		1	
Max	25,381		3,220	

*Includes providers with at least 1 patient served under Program Code 02 or 04 in 2010.

This methodology identifies only slight more than half the number of providers as the encounter methodology. However, it may accurately reflect the reality that fewer managed care providers are high volume providers of care for Medi-Cal patients.

Safeguards: This methodology has the same difficulty as the patient encounter methodology in dealing with the very high volume providers. It is possible that some providers have healthier panel patients who are seen less frequently than 3.2 times per year. It seems unreasonable that any provider could see a Medi-Cal patient panel more than 2 times the number of 1060 expected for a full time practitioner seeing only Medi-Cal panel patients. Also, the California Code of Regulations (Title 28, Division 1, Chapter 1, §1300.67.2) specifies that there shall be at least one full time equivalent primary care physician for each 2000 enrollees in a health plan. For these reasons, DHCS plans to set an upper limit of 2000 panel patients for the purposes of prequalification. This would eliminate the top 1% of Medi-Cal panel providers from prequalification. Also, similar to the patient encounter methodology, providers will be required to sign an attestation form including the following:

> "I have been prequalified by Medi-Cal for the EHR Incentive Program based on having at treated at least 318 Medi-Cal panel patients in 2010 documented in claims and encounter data held by Medi-Cal. I attest that I personally delivered the services for at least 318 Medi-Cal panel patients in 2010."

Potential Advantages: The patient panel prequalification methodology has potential advantages similar to those of the patient encounter prequalification methodology, particularly with respect to limiting the amount of prepayment verification that DHCS staff will have to carry out using managed care encounter data, which is known to be incomplete

and inaccurate in many aspects. The quality of Medi-Cal managed care encounter data is expected to improve in future years in response to planned initiatives, but these improvements will not benefit the Medi-Cal EHR Incentive Program for at least two years because of the retrospective nature of eligibility determination. Medi-Cal managed care plans are supportive of the panel prequalification methodology. A copy of a letter of support from CEO of Inland Empire Health Plan is provided in Appendix 3.

Clinic Methodology

Office of Statewide Health Planning (OSHPD) Annual Utilization Report of Primary Care Clinics: The basic approach to prequalifying clinics will involve using data from the OSHPD Annual Utilization Report of Primary Care Clinics to determine which clinics in 2010 had 30% or more of encounters attributable to Medi-Cal patients and needy individuals. Licensed clinics in California (including FQHCs) are considered 1204a clinics due to the statutory section that governs them (see Appendix 4). 1204a clinics are either community clinics or free clinics and all are required to be non-profit and treat patients for free or charge based on their ability to pay. All 1204a clinics, including FQHCs, are required to report the same data annually to the Office of Statewide Health Planning and Development (OSHPD). For these reasons it is justified to treat them all equally for the purposes of prequalification with the exception that clinics that are not FQHCs or RHCs would not be eligible for prequalification based on needy individual encounters. The OSHPD data base is very robust with regard to payment sources and allows for easy delineation of Medicaid encounters from needy individual encounters. OSHPD has posted the clinic data through 2010 on its website (http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html). This report contains all of the information needed for determination of clinic-wide patient volumes and, unlike claims and encounter data, contains accurate data on all payer sources that can be used to generate all-payer denominators. The data in the OSHPD report tends to be highly accurate since it is generated by electronic practice management systems in over 90% of the clinics. The payment source categories in the OSHPD report and their relevance to eligibility for the Medi-Cal EHR Incentive Program are listed below:

- Medicare
- Medicare Managed Care
- Medi-Cal (Medi-Cal/ Needy)
- Medi-Cal Managed Care (Medi-Cal/ Needy)
- County Indigent/ CMSP/ MISP (Needy)
- Healthy Families (California CHIP) (Needy)
- Private Insurance
- Self-Pay/ Sliding Fee (Needy)
- Free (Needy)
- Breast Cancer Programs
- Child Health and Disability Prevention Program (Medi-Cal/ Needy)
- EAPC (Expanded Access to Primary Care) (Needy)
- Family PACT (Medi-Cal/ Needy)
- PACE Program
- LA County Public Private Partnership
- Alameda Alliance for Health
- Other County Programs
- All Other Payers
- Total

Impact of Prequalification: Analysis of the 2010 OSHPD data indicates that approximately 83% of FQHC clinic sites would be prequalified at the 30% Medi-Cal volume level and 97% at the 30% needy individual level (see Table 2).

Table 2: 2010 OSHPD Encounters

FQHC Total	*563*			
	466	30%	Medi-Cal	83%
	436	35%		77%
	397	40%		71%
	544	30%	Needy	97%
	533	35%		95%
	526	40%		93%
Non- FQHC Total	*394*			
	194	30%	Medi-Cal	49%
	184	35%		47%
	173	40%		44%

For the non-FQHC sites, 194 would be prequalified, representing approximately 50% of all non-FQHCs. Even if the prequalification threshold was set at 35% or 40% the proportion of clinics that could be prequalified would be very substantial. However, given the accuracy of the OSHPD data setting a threshold higher than 30% does not seem justified.

Potential Advantages of Prequalification: One of the hallmarks of primary care clinics is that they operate a team based care model and as such bill by the entity, not by the rendering provider. This billing model poses difficulties because Medi-Cal cannot easily confirm through the claims and encounter data that a provider at a clinic was responsible for a particular encounter. Prequalification using OSHPD data overcomes this problem for the vast majority of clinic providers and makes the use of claims and encounter data unnecessary for confirming patient volumes. This methodology also provides a rich source of information about needy individual encounters and commercial payer encounters that is not available from Medi-Cal claims and encounter data. The clinic community in California is highly supportive of prequalification of clinics using OSHPD data. A copy of a letter of support from the California Primary Care Association is provided in Appendix 5.

DHCS believes that prequalification of clinics is a necessary adjunct to prequalifying providers. This is because providers who receive notification that they have been prequalified on the basis of their individual encounters may see little motivation to qualify for the program as a member of their group or clinic. If such high volume providers do not participate as group or clinic members many group or clinic providers with less than 30% patient volumes may not be able to qualify for the program. Prequalification of clinics will enable them to proactively educate their providers and enroll them for group eligibility. To assist clinics and groups DHCS is considering opening the SLR Clinic/Group portal 1-2 months before opening the SLR EP portal. This will give clinics and groups the chance to designate the EPs in their groups before EPs enter the SLR. Additionally, when a prequalified provider enters the SLR and has already been designated as a clinic/group member, the SLR will default his/her eligibility to the clinic or group.

Overall Prequalification Impact

It is difficult to accurately project the total number of Medi-Cal providers who could be prequalified by these methods since some would undoubtedly be prequalified by more than one method. Analysis of MIS/DSS data indicates that roughly 20% of the providers who

would prequalify on the basis of encounters would also prequalify based on being providers in clinics that have been prequalified. Similarly, some of the providers that would be prequalified on the basis of having patient panels of 313 or more would also be prequalified because of having 1116 or more encounters in 2010. Starting from a base of 8% for encounter prequalification and adding 4% for panel prequalification and roughly another 2% for clinic prequalification (although this percentage might be too conservative), it is possible that prequalification might identify up to14% of Medi-Cal providers as eligible for the program. This would be over half of the Medi-Cal providers that the Lewin Group and McKinsey & Company report projected would be eligible for the program.

Appendix 1

Table 5

Average number of family physician visits per week and average number of patients in various settings, June 2008

	Office Visits	Hospital Visits	Nursing Home Visits	House Calls	Patients Supervised Under Home Health Care	Nursing Home Patients Supervised	Hospice Patients Supervised	Patients with Free or Discounted Care
Total	84.9	8.1	2.3	0.6	7.5	9.6	2.1	9.5
Census Division								
New England	77.3	3.7	1.4	. 1.0	9.7	5.4	1.0	10.4
Middle Atlantic	90.4	9.1	3.0	0.5	1.0	15.1	1.3	6.9
East North Central	84.8	8.2	2.7	0.9	6.4	10.3	1.4	7.2
West North Central	82.3	10.7	2.8	0.2	7.9	13.7	2.5	7.0
South Atlantic	90.3	7.8	3.3	0.8	7.3	11.1	3.1	11.0
East South Central	116.5	14.2	3.5	0.6	13.7	10.4	5.1	9.4
West South Central	92.9	9.3	2.6	0.8	10.9	11.7	2.9	12.8
Mountain	63.9	6.4	1.1	.0.3	6.1	5.0	1.4	9.7
Pacific	74.9	3.9	1.9	0.4	3.2	7.1	1.1	10.4
Location								
Urban	82.4	6.4	1.9	0.6	6.8	8.2	1.9	9.0
Rural	92.9	13.4	3.7	0.6	9.8	13.9	2.7	11.0
Completion of FP Residency								
FP Residency Graduate	83.9	8.1	2.3	0.6	7.5	9.7	2.1	9.6
Not FP Residency Graduate	101.5	8.9	2.2	0.3	7.7	7.6	2.4	7.9

**Based on survey responses of 1,054 active members of the American Academy of Family Physicians, including those with no visits in any setting.*

Source: American Academy of Family Physicians, Practice Profile I Survey, June 2008

INGENIX

Department of Health Care Services

Scope Document/Data Request Form

Date: May 4, 2011
From: Daria Rostovtseva
To: Dr. Larry Dickey
Copies: Steve Yegge, Raul Ramirez, Steve Grimshaw, Karen Duong

IR #: 6396
Subject: Individual Managed Care providers with a panel of 300+ patients in 2010

Background

The Office of Health Information Technology (OHIT) would like to estimate the proportion of individual Managed Care providers who may be prequalified for the EHR incentive payment program.

Scope

Ingenix will prepare a report on the distribution of the estimated panel size per provider in 2010, by provider type. The proportion of providers with panels of 300 or more patients will be calculated.

Proposed Selection Criteria

Program codes 02 and 04 will be included (02 – Managed Care plans, 04 - COHS).

Claims and encounters with the following aid codes will be excluded: 0R, 0T, 2V, 4V, 53, 65, 7M, 7N, 7P, 7R, 71, 73, and 81.

Claim types identifying pharmacy and institutional charges, such as room & board, will be excluded (fi_claim_type_cd= ‘01’,’02’,’03’ and claim_type_cd=’2’,’3’).

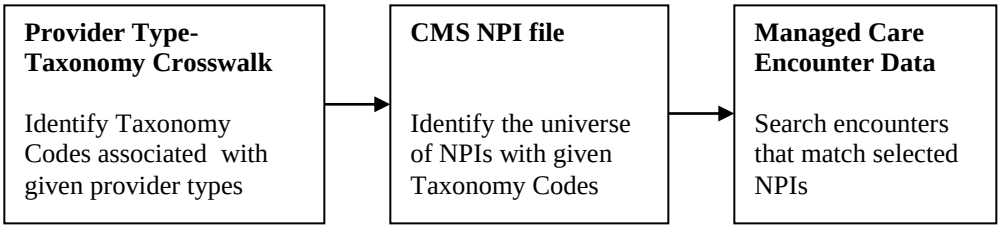
Patient panel will be estimated as the number of unique patients seen by the provider in 2010. Unique providers are identified by NPI and Service Location Number. Unique patients are identified by patient CIN. Year of service is determined by the Service-From date on the claim header.

We will use the matched provider number to capture all Managed Care records associated with the provider. All providers with valid NPIs will be included, regardless of whether the provider is found in the PMF.

Patients will be attributed to providers according to the following logic. If the rendering provider field is populated and the number can be linked to a valid NPI, the patient will be attributed to this NPI. Otherwise, the encounter will be attributed to the billing provider NPI.

Provider types 005 (nurse midwife), 007 (nurse practitioner), 020 (optometrists) 026 (physicians), 099 (dentists) will be included. Note that provider type is unknown for

providers not present in the PMF. However, taxonomy codes are available for all providers with valid NPIs from the CMS NPI file. To capture all providers of these types, we will utilize the Provider Type-Taxonomy crosswalk available in the MIS/DSS data warehouse to identify the universe of NPIs that match these criteria. The diagram below shows, in a simplified way, the steps involved in this process:



Report Format

Report will be delivered in the form of a PDF document. There will be no PHI in the report.

Proposed Report Generation and Delivery Schedule

The work proposal below assumes that the report is generated using the criteria established in this document.

Date Due	Task	Responsibility
5/6/2011	Scope approved	Ingenix/OHIT
5/16/2011	Report delivered	Ingenix
TBD	Changes requested by OHIT, report revised as necessary	Ingenix/OHIT

Data Issues

There are two significant data issue in this analysis:

- Quality of Managed Care provider information. Prior research found that provider information populated on Managed Care encounter data lacks quality, particularly on program code 02 records. Rendering provider field is frequently not populated or mapped. Both billing and rendering provider fields are often populated with numbers that cannot be matched to the available provider information.

- Data lag. Managed Care data has substantial time lags and is sometimes inconsistently submitted by health plans.

Appendix 3

June 8, 2011

Jenny Chen
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services, Region IX
Department of Health and Human Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: California's State Medicaid HIT Plan and Proposal for Prequalification

Dear Ms. Chen:

On behalf of the Inland Empire Health Plan (IEHP), I am writing in support of the prequalification proposal submitted by the California Department of Health Care Services (DHCS).

IEHP, a Knox-Keene licensed Health Plan located in San Bernardino, California, is a not-for-profit public agency serving low income, vulnerable populations. IEHP serves San Bernardino and Riverside Counties and has over 500,000 Members in the following programs: Medi-Cal (including seniors and people with disabilities), Healthy Families, Healthy Kids, and a Medicare Advantage Special Needs Program. Through a dynamic partnership with providers, award-winning service and innovative products, IEHP is fully committed to providing our Members with quality, accessible and wellness based healthcare services.

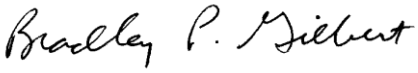
IEHP is strongly supportive of the HITECH EHR Incentive Programs and has partnered with both county medical societies to operate a local extension center assisting providers in our community with EHR implementation. We believe that it is important to expedite the distribution of incentive program funding to providers and that DHCS's proposal to "prequalify" a large number of providers based on state-held data is an efficient and statistically sound way to accomplish this. I personally participated on the advisory group to develop this proposal and am particularly pleased to see that DHCS has proposed a multi-pronged methodology that can apply to managed care providers as well as fee-for-service providers.

IEHP will continue to work with DHCS on the SMHP and will provide any assistance necessary to launch a successful Medi-Cal EHR Incentive Program in California.

P.O. Box 19026, San Bernardino, CA 92423-9026
Tel (909) 890-2000 Fax (909) 890-2019 For TTY Users (909) 890-0731
Visit our website at: www.iehp.org

Thank you for the opportunity to provide this letter of support. If you have any questions please contact me at (909) 890-2010 or gilbert-b@iehp.org. Thank you for your attention and consideration.

Respectfull
y,



Bradley P. Gilbert, M.D.,
M.P.P. Chief Executive Officer

Appendix 4

California Health and Safety Code Section 1204(a)

1204. Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services.
In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third-party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

Appendix 5

June 8, 2011

Jenny Chen
Division of Medicaid & Children's Health Operations Centers for Medicare and Medicaid Services, Region IX Department of Health and Human Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: California's State Medicaid HIT Plan and Proposal for Prequalification

Dear Ms. Chen:

On behalf of the California Primary Care Association (CPCA), the 850 nonprofit community clinic and health centers (CCHCs) throughout California, and the approximately 3,500 eligible professionals employed or contracted with the clinics I am writing to support the prequalification proposal submitted by the Department of Health Care Services Office of Health Information Technology (DHCS OHIT).

CPCA has been working closely with DHCS OHIT on the meaningful use incentive program since it was announced as part of the HITECH Act in 2009. The providers at the clinics and health centers in California face a significant barrier to qualifying for the incentive payments as they are employed or contracted by the CCHCs to deliver services and as such bill through the CCHC. The state of California does not have a system that captures which provider provided an encounter at a clinic site because it is the CCHC site that bills for the visit. CMS' allowance for group proxy was a tremendous help in developing a path for our member providers to prove eligibility, and the prequalification by group proposed by DHCS OHIT even more so.

Prequalifying clinics using OSHPD data is an efficient and straightforward process. CPCA and our membership are very proud of our reporting to the Office of State Health Planning and Development (OSHPD) as it assists us in maintaining a transparent and accountable health care delivery system for the safety net. This annual reporting is required of all licensed 1204(a) clinics in California. It tracks not only encounters by payer source, but patients seen, language, race/ethnicity, provider type, etc. As DHCS OHIT has conveyed in their proposal already, the data is self reported, but is pulled from

the electronic practice management systems that are ubiquitous throughout clinics in California and have been used for many years. As such, we are confident in the prequalification method using OSHPD data.
CPCA will continue to work with DHCS OHIT on the SMHP and will provide any assistance necessary to launch a successful program in California.

Thank you for allowing us to provide this letter of support. If you have any questions about content, please do not hesitate to contact our Assistant Director of Policy, Andie Patterson, at (916) 440-8170 or apatterson@cpca.org. Thank you for your attention and consideration.

Sincerely,

Carmela Castellano-Garcia, Esq.
President and CEO
California Primary Care Association